



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

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COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Terry Raney, Guardianship and Legal Services Coordinator,
Virginia Department for the Aging

DATE: May 20, 2003

SUBJECT: Home/Vehicle First Aid Kit

Sometimes commercially available first aid kits do not meet the needs of seniors. Here are recommendations for a home or travel first aid kit that may be better for seniors than what can be found in stores. The overall cost of this kit is probably less than what is commercially available.

This information is provided by Laura E. Snipes, RN, BSN, MSN a home health nurse in Richmond, VA.

Enclosure



Home/Vehicle/Travel First Aid Kit

Things for a First Aid kit:

Packets of aspirin tablets - for someone having a heart attack

Packets of Benadryl tablets - for an allergic reaction

Tube of cake icing - for a diabetic low blood sugar episode

Tube of Neosporin antibiotic ointment

Small pair of scissors

Ace bandage

Several 4X4 dressings

Dressing tape

"Kling" gauze wrap dressing

Band-Aids, various sizes

A pocket size CPR mask

Latex Free gloves

A few small trash bags

Some paper towels

Alcohol hand washing gel

Travel size bottle of hand soap

Instant ice pack

Note pad and pen - to record important information

First Aid/CPR information cards

Check contents every month for expired or damaged items. Replace as needed.

Place items in a red, zippered bag so you can easily find it.

Take a CPR and First Aid class if you haven't had one in the last 2 years.



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Cecily Slasor

DATE: May 20, 2003

SUBJECT: Fact Sheets in Spanish for Family Caregivers

The Family Caregiver Alliance, a national information center on long-term care located in California, has produced 17 Fact Sheets in Spanish for caregivers. The Fact Sheets cover a range of diseases, conditions such as Alzheimer's, stroke, Parkinson's disease and others. Caregiving tips, health conditions, legal issues, and end-of-life planning are among the topics covered.

The Fact Sheets can be downloaded from the website at:
www.caregiver.org/news_releases/20030423_spanish_fsheetsC.html





COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Trudy Maske
Program Coordinator

DATE: May 20, 2003

SUBJECT: "Operation Red Flag"

Attached please find this month's issue of "Operation Red Flag" consumer protection tips. They have been designed to help older Virginians to recognize the problems existing in our health care system. These sheets contain educational messages and "tips" that will help members of the general public prevent Medicare and Medicaid fraud. Please post these in your centers and give copies to the seniors you serve.

If you have any questions, please contact Trudy Maske Program Coordinator Center for Elder Rights, Virginia Department for the Aging, at (804) 662-7671, or contact VDA at 1-800/552-3402.

Thank you

cc: Janet Riddick
Director, Center for Elder Rights



Operation Red Flag

The federal government's General Accounting Office estimates for every \$10 spent on Medicare, a conservative estimate is that \$1 is either lost to fraud, waste, or abuse. In 1999 this amounted to \$13 billion. Who pays? We all do – because fraud drives up costs and makes your annual deductible and monthly premiums higher than they have to be. We must take responsibility for becoming better health care consumers and win this battle, so that the Medicare and Medicaid programs will be around for future generations. Call or write to the phone number or address at the bottom of the sheet with any suspected health fraud, waste, and abuse.

Be Informed . . . Be Aware . . . Be Involved!

How to Report Suspected Medicare Fraud and Abuse

If you believe Medicare is being defrauded, call or write the Medicare company that paid the claim. The name, address, and telephone number are on the Medicare explanation of benefits, which shows what Medicare paid.

Before contacting the claims processing company, carefully review your statements. Write down:

- your Medicare or Medicaid Number;
- the provider's name and any identifying numbers you have;
- the date on which the item or service was supposedly furnished;
- the item or service you have questions about;
- the date of the Medicare Summary Notice (MSN) or Medicare Statement;
- the amount approved and paid;
- the reason you believe the bill should not be paid; and
- any other information needed for the call.

Clearly state at the beginning of your call or letter that you are filing a fraud complaint. Specify whether it is Medicare or Medicaid. This will help to ensure that your complaint is forwarded properly.

To Report Suspected Medicare or Medicaid Fraud

Call 1-800/552-3402 (Voice/TTY)

Or Write to Address Below



Center for Elder Rights

Consumer Protection Technical Assistance Resource Center

1600 Forest Avenue, Suite 102, Richmond, VA 23229

804/662-9333 (Voice/TTY) Fax: 804/662-9354 www.aging.state.va.us

03/11



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

May 20, 2003

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Bill Peterson
Deputy Commissioner for Programs

SUBJECT: **Lifespan Respite Act**

As you may already know, The US Senate has passed the Lifespan Respite Care Act (S. 538). It is now awaiting House passage. The Senate Bill is sponsored by Senator Hillary Rodham Clinton (NY), Senator John W. Warner (VA), Senator John Breaux (LA), Senator Olympia J. Snowe (ME) and Senator Barbara A. Mikulski (MD).

The Act would provide \$90 million in grants for states and local bodies to increase the availability of respite care in their regions. Attached is an overview of the Lifespan Respite movement.

Attachment



Lifespan Respite

What Is Lifespan Respite?

Lifespan Respite is a coordinated system of accessible, community-based respite care services for caregivers and individuals regardless of age, race, ethnicity, special need or situation. Respite care is planned or emergency short-term relief to caregivers from the demands of ongoing care for an individual with special needs or at risk of abuse or neglect. Special needs may include any disability, any chronic or terminal physical, emotional, cognitive or mental health condition requiring ongoing care and supervision, including Alzheimer's disease and related disorders, developmental disabilities, children with special medical needs, and any other condition determined by the state. Crisis respite may also be used to provide a temporary safe haven for the care recipient in the event of an emergency brought on by domestic violence, substance abuse, or a housing, health or job crisis.

States Move Toward Passing Lifespan Respite Bills

- As of April 2001, three states had passed Lifespan Respite Acts (OR, NE, WI), which establish state and local infrastructures for developing, providing, coordinating and improving access for lifespan respite to residents of the state who are eligible for such services. Oklahoma has implemented a Lifespan Respite Program without legislation. Maryland has passed a bill, which establishes a statewide respite coordinator (MD). Several other states are actively considering or piloting similar programs or legislation.
- The need for state and national respite infrastructure is compelling. In the last year, the National Family Caregiver Support Act (NFCA) was enacted and implemented across the country. This Act establishes a family caregiver support system that provides respite, support and counseling services through area agencies on aging, but is

available only for individuals caring for the elderly, and to a much lesser extent, older caregivers caring for grandchildren or adult children with disabilities. While NFCA recognizes the value and justifies the need for a system of respite care and caregiver support, there is no single, coordinated, family/caregiver friendly federal program to support the development or implementation of Lifespan Respite Services nationwide. This is especially compelling because numerous federal programs continue to have the potential, although they may not have adequate resources, to fund respite or crisis services for caregivers of individuals with specific disabilities, specific ages, or for one narrow purpose. As a result of this fragmentation and insufficient dollars, State governments, as well as families are still forced to search for services, funding, and support, where they may or may not exist, often in a complicated bureaucratic maze (Guide to Federal Funding for Respite and Crisis Care Programs, ARCH, July 1999)

- In a survey of 33 caregiver support programs in 15 states, it was found that eligibility criteria for programs vary widely by diagnostic /functional level, age and income. Over two thirds of these programs provide five or more caregiver services, most typically respite care. For respite assistance in particular, service definition, eligibility, mode of delivery and funding vary widely across programs and within states. Key informants report that while respite care is among the most beneficial aspects of their programs, recruiting respite workers/raising worker wages is also among the biggest challenges these state programs face. Respondents recommended more funding in general and more funding for respite care in particular. Oregon's Lifespan Respite Care Program was identified as one of the five best practice models among the 33 programs surveyed (Family Caregiver Alliance, Oct. 1999).

Lifespan Respite

- The Olmsted decision compelled the National Conference of State Legislatures to offer states assistance in developing long-term community-based services for the elderly and people with disabilities. In a recent NCSL Issue Brief, Promising Practices: Community-Based Long-Term Care, the following three models were identified: consumer directed care, managed long-term care and enhanced respite care. The Nebraska Lifespan Respite Program was highlighted (National Conference of State Legislatures, May 2001).

The Need for Respite Care is Overwhelming

Respite has been shown to be a key component, one that families and caregivers most often request, of child care, elder care, comprehensive family support, family caregiver, health and long-term care, family violence or child abuse prevention strategies. Yet, respite remains in critically short supply for all age groups, for all families in crisis, and for caregivers of the elderly and individuals with disabilities.

- During an average week, nearly 1,500 families representing 3,425 children are turned away from respite and crisis care programs because resources to meet the need are absent. In a 1998 survey of respite programs nationwide, half had families waiting for respite care at the time of the survey (ARCH National Resource Center on Respite and Crisis Care, 1999). Twenty of 35 state-sponsored respite programs for the older population surveyed in 1991 reported that they were unable to meet the demand for respite services (Lindeman and Soos, 1991)
- By 2020, the number of adults requiring assistance with daily living will increase to almost 40 million and the number of elderly requiring long-term care will double (General Accounting Office, 1994). More than half of Americans (54%) say it is likely that they will be responsible for the care of an elderly parent or relative in the next ten years (National Partnership for Women and Families, 1998). Despite these numbers, families caring for the elderly or adults with disabilities have even fewer respite options.
- Current estimates suggest that there are between 24 and 28 million family caregivers in America. One estimate suggests that they may be as many as 54 million people who were caregivers for a family member or friend in 2000 (National Family Caregiver Association, July 2000). About 60 to 65% of the individuals requiring care are the elderly (Gould, United Hospital Fund, Summer 1999). According to the National Survey of Families and Households, an estimated one-third of adults between the ages of 20 and 75 are providing some type of informal care to an ill or disabled family member or friend. The largest share of this informal caregiving goes to parents (38%), next to non-kin (24%), other relatives (20%), spouses (11%), and children (7%) (Stone, Robyn, Family Caregiver Alliance Conference proceedings, Oct. 1999).
- Families of children with disabilities or chronic illness have unique and ongoing needs that present special demands and can increase family stress. Over six million children who have a disability or developmental delay are eligible for or receive special education and related services under the Individuals with Disabilities Education Act (IDEA), including IDEA's preschool and early intervention program. (U.S. Department of Education, Twenty-second Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2000)

Elderly grandparents, often without adequate family supports, are acting as primary caregivers of their grandchildren, with and without disabilities. Currently, there are more than 2.5 million grandparent-headed households raising 3.9 million children in the U.S. The number of these families without either parent present increased 53% between 1990 and 1998 and now over 1.3 million children are being raised solely by their grandparents (U.S. Bureau of the Census, 1998 Current Population

Survey). Despite these statistics, most states and counties do not fund respite for these caregivers (Generations United, Jan. 2000).

Millions of Families Face Serious Stressors That Can Lead to Abuse

Millions of families without appropriate supports, such as respite, face overwhelming stress related to joblessness, homelessness, isolation, poverty, substance abuse or violence which places their children or other family members at high risk of abuse.

- In 1999, 826,000 children were the victims of substantiated or indicated child abuse and neglect. CPS agencies investigated an estimated 2 million reports alleging the maltreatment of almost 3 million children (Department of Health and Human Services, Press Release, April 2, 2001)
- Without adequate family support, it is estimated that children with disabilities are 3.76 times more likely to be victims of neglect, 3.79 times more likely to be physically abused, 3.88 times more likely to experience emotional abuse, and 3.14 times more likely to be sexually assaulted than children without disabilities (Sullivan & Knutson, 2000).
- Experts estimate that as many as 32 out of 1,000 elderly people are victims of elder abuse (Journal of the American Geriatrics Society 2000, 48: 205-208). A 1996 national incidence study found that 450,000 persons aged 60 and over in domestic settings experienced abuse or neglect in a one-year period. It is estimated that over five times as many new incidents of abuse and neglect were unreported than those that were reported to and substantiated by Adult Protective Services agencies in 1996. In 90% of cases, the perpetrator was a family member; two-thirds of the perpetrators were adult children or spouses. (The National Elder Abuse Incidence Study, National Center on Elder Abuse, Sept. 1998).

- It is estimated that 2 to 4 million women are victims of domestic violence, and between 3.3 and 10 million children are exposed to domestic violence, each year (Novello, Antonio, 1992; Future of Children, Winter, 1999). Yet prevention and intervention services are in short supply. The 1997 National Directory of Domestic Violence programs indicates that the total number of shelter-based programs had grown to 1,305, and that 72.4% of those programs offered some type of children's services (Saarhoff and Stoffel, 1999). However, many battered women do not utilize shelters either by choice or because these services are not available (Future of Children, Winter 1999). In addition, although most children exposed to domestic violence do not go to shelters, only 56% of 1,886 community-based domestic violence providers offered some form of services for nonresident children (Saarhoff and Stoffel, 1999).

Substantial numbers of the 1.8 million children in all types of kinship care (private, foster care, voluntary) face socioeconomic risks to their health and development. Two in five (41%) live in families with income less than 100% of the federal poverty level and one in three (36%) live with a caretaker without a high school degree. Of even greater concern, one in five (20%) face three or more risks simultaneously (Urban Institute, February 2001).

Caregiving Takes a Significant Toll on the Caregiver and the Caregiver's Family

- As many as one-fourth to two-thirds of caregivers report physical or mental health problems due to caregiving. A recent survey of caregivers of children, adults and the disabled conducted by the National Family Caregivers Association, found that while 70% of the respondents reported finding an inner strength they didn't know they had, 27% reported having more headaches, 24% reported stomach disorders, 41% more back pain, 51% more sleeplessness and 61% reported more depression (National Family

Lifespan Respite

Caregivers Association, <http://nfcacares.org/survey.html>, April 30, 2000).

- A recent JAMA study found that participants who were providing care for an elderly individual with a disability and experiencing caregiver strain had mortality risks that were 63% higher than noncaregiving controls (Schulz and Beach, December 1999).
- The financial stress, as well as the poor health status of grandparent caregivers can be enormous. In 1997, grandparent caregivers were 60% more likely to live in poverty than grandparents not raising grandchildren. In addition, in 1997, 33.6% of grandmothers and 28.7% of grandfathers of all grandparent-maintained families self-reported their general state of health as fair or poor (Generations United, Jan. 2000).
- Forty-two percent of families of children with special needs lack basic workplace supports such as paid sick leave and vacation time (National Family Caregiver Association, Spring 2001) and their families face a significantly higher divorce rate than families of children without disabilities (U.S. House of Representatives, Select Committee on Children, Youth, and Families, 1984).
- In an Iowa survey of parents of children with disabilities, a significant relationship was demonstrated between the severity of a child's disability and their parents missing more work hours than other employees. They also found that the lack of available respite care appeared to interfere with parents accepting job opportunities. (Ableson, A.G., 1999)

Respite is Not Costly and it Works

Without respite and other supports for family caregivers, many additional older individuals, adults with disabilities and children would receive more costly care services in institutional or foster care placements.

Respite for Younger Family Members with Disabilities Improves Family Stability, Reduces Chances of Out-of Home Placements

- Respite has been shown to improve family functioning, improve satisfaction with life, enhance the capacity to cope with stress, and improve attitudes toward the family member with a disability (Cohen and Warren, 1985). In a 1989 national survey of families of a child with a disability, 74% reported that respite had made a significant difference in their ability to provide care at home; 35% of the respite users indicated that without respite services they would have considered out-of-home-placement for their family member (Knoll, James, Human Services Research Institute, March, 1989)
- There was a statistically significant reduction in somatic complaints by in a study of primary caregivers of children with chronic illnesses, and a decrease in the number of hospitalization days required by children, as a direct result of respite care (Sherman, B.R., 1995).
- Preliminary data from an ongoing research project of the Oklahoma State University on the effects of respite care found that the number of hospitalizations, as well as the number of medical care claims decreased as the number of respite care days increased (FY 1998 Oklahoma Maternal and Child Health Block Grant Annual Report, July 1999). A Massachusetts social services program designed to provide cost-effective family-centered respite care for children with complex medical needs found that for families participating for more than one year, the number of hospitalizations decreased by 75%, physician visits decreased by 64%, and antibiotics use decreased by 71% (Mausner, S., 1995).
- An evaluation of the Iowa Respite Child Care Project for families parenting a child with developmental disabilities found that when respite care is used by the families, there is a statistically significant decrease in foster care placement (Cowen, Perle Slavik, 1996).
- A study of Vermont's 10 year old respite care program for families with children or adolescents with serious emotional disturbance

found that participating families experience fewer out-of-home placements than nonusers and were more optimistic about their future capabilities to take care of their children (Bruns, Eric, November, 15, 1999).

Similar Positive Results Found When Caregivers of the Elderly Use Respite

- Respite care for the elderly with chronic disabilities in the study group resulted in fewer hospital admissions for acute medical care than for two other control groups who received no respite care (Chang, J.I., Karuza, J., Katz, P.R., et al, Journal of the American Board of Family Practice, 5: 1992).
- Sixty-four percent of caregivers of the elderly receiving 4 hours of respite per week after one year reported improved physical health, 78% improved their emotional health, and 50% cited improvement in the care recipient as well. Forty percent said they were less likely to institutionalize the care recipient because of respite (Theis, S.L., et al, 1994).
- Caregivers of relatives with dementia who use adult day care experience lower levels of caregiving related stress and better psychological well-being than a control group not using this service. These differences are found in both short-term (3 months) and long-term (12 months) users. (Zarit, S.H. et al, 1998)

Crisis Respite or Respite for High Risk Families Improves Family Functioning, Prevents Abuse and Neglect

- Very high percentages of children in high-risk families using crisis respite have avoided reports to child protective services, and most remain living safely with their families. One Iowa crisis program found a 13% decrease in the reported incidence of child abuse and neglect in the initial four pilot counties after the program's implementation (Cowen, Perle Slavik, 1992).
- An evaluation of a respite care project targeted to families in a high risk community

found that: one out of four mothers reported positive changes in their relationships with their children, and 50 percent of the mothers noted positive changes in their children's behavior. Of the 25 families referred to the project following a request for child placement, over two-thirds did not proceed with placement plans. (Home, A. and Darveau Fournie, L., 1995).

- In a recent evaluation study of families of children at risk of abuse or neglect who utilized Family Support Services of the Bay Area's Respite Care Program in northern California, over 90% of the families using the service reported reduced stress (93%), improved family relationships (90%), improved positive attitudes toward child (93%), and other significant benefits that can help reduce the risk of abuse (Owens, Sandra, et al, School of Social Welfare, Berkeley, California, 1999).
- In April, 1999, the Minnesota Dept. of Human Services, Family and Children's Services Division, reported that crisis nursery clients in 15 crisis nursery programs serving 18 counties showed a 67% reduction in child protection involvement after using nursery services. The Hennepin County Children and Family Services Department's evaluation of the Greater Minneapolis Crisis Nursery found that families with prior child protection involvement who used the Nursery had only an 8% risk factor compared with an 84% risk factor for families who did not use the Nursery.
- The Relief Nursery in Eugene, Oregon, reports that in 1997-98, 91.3% of children attending the Nursery were free of any reports of abuse, and 89% had no involvement with foster care. This is remarkable, because two-thirds of the families had more than ten risk factors, and 95% had five or more. A family with five risk factors is deemed to be at extremely high risk for abuse and neglect.

Lifespan Respite

- Of the more than 25,000 children whose families used the services of the Vanessa Behan Crisis Nursery (a 24-hour, 7-day-a-week shelter program for at-risk children in Spokane, WA), not one has sustained a life-threatening injury since the nursery opened its doors in 1987 (U.S. Dept. of Justice, Safe from the Start," November, 2000).

Respite Provided Across the Lifespan Yields Positive Outcomes

- In Nebraska, a newly formed statewide lifespan respite program conducted a state-wide survey of a broad array of caregivers who had been receiving respite services, and found that one out of four families with children under 21 reported that they were less likely to place their child in out-of-home care once respite services were available. In addition, 79% of the respondents reported decreased stress and 58% reported decreased isolation (Jackson, Barbara, Munroe-Meyer Institute, University of NE Medical Center, January 2001).
- Preliminary findings of an outcome based evaluation being piloted in 17 respite and crisis respite sites serving different age groups across the country are promising. While only fifteen (15%) percent of the caregivers reported that it was "somewhat likely" to "highly likely" that their child might have been mistreated or neglected if crisis care had not been available, and an additional 15% responded "not sure," 81% reported that the crisis care they received helped protect their child from danger. Ninety percent (90%) of the caregivers found that crisis care reduced their stress "quite a bit," "very much," or "extremely," with "extremely" accounting for nearly 3/5 (57%) of respondents. More than half (54%) reported that with respite, their relationship with their dependant family member had improved "quite a bit," very much," or "extremely" (Kirk, Raymond, and Wade, Casandra, 2001)

Family Caregivers Save the Government Billions of Dollars—Respite Saves the Caregivers

- According to the National Long-Term Care Survey, which includes only caregivers of adults over 65 enrolled in Medicare, there are over seven million people who are informal caregivers who provide unpaid help to older people living in the community with at least one limitation in their activities of daily living. According to the survey, if the work of these caregivers had to be replaced by paid home care staff, the cost to our nation would be \$45 to \$75 billion per year (U.S. Dept. of Health and Human Services, Administration on Aging website, www.aoa.dhhs.gov/May99/caregier.html). Other studies have suggested that caregivers now provide nearly \$200 billion per year in unpaid care, saving the government billions of dollars in paid institutional long-term care costs (McConnell, Stephen, Family Caregiver Alliance Conference Proceedings, Oct 99).
- U.S. businesses also incur high costs in terms of decreased productivity by stressed working caregivers. A recent study by MetLife estimates the loss to U.S. employers to be between \$11.4 to \$29 billion per year. This includes replacement costs for employees who quit because of overwhelming caregiving responsibilities, absenteeism, and workday interruptions. (Metropolitan Life Insurance Company, 1997)

Respite care is one of the services that Alzheimer's caregivers say they need most. A recent study found that if respite care delays institutionalization of a person with Alzheimer's disease by as little as a month, \$1.12 billion is saved annually (Leon, et al., 1998). A similar study in 1995 found that as respite use increased, the probability of nursing home placement decreased significantly (Kosloski, K. and Montgomery, R.J.V., 1995).

Prepared by Jill Kagan, MPH, Chair, National Respite Coalition, May, 2000, rev. August, 2001. Detailed references available upon request.



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau, Human Services Program Coordinator

DATE: May 20, 2003

SUBJECT: National Family Caregivers Support Program – Statewide Conference for Aging and Developmental Disabilities Professionals

The Arc of the United States received a grant from the Administration on Aging under the National Family Caregivers Support Program. The Arc project will work to build service capacity to aging network constituents and disability provider organizations through cooperative planning, coordinating and supportive services to older caregivers of children and adults with intellectual and developmental disabilities. As part of this project, the Arc of the Northern Shenandoah Valley will be conducting a technical assistance and training program to help aging individuals with developmental disabilities and their caregivers gain access to services. I participated in a planning session for this event and, it promises to be an informative workshop.

The Arc of the Northern Shenandoah Valley workshop will be held, Friday, July 11, 2003 at the Lord Fairfax Community College Special Events Center in Middletown, Virginia from 9:00A.M. until 4:30 P.M. Information on the agenda, speakers and registration is attached. Contact for this event is Lana Hurt, Arc of the Northern Shenandoah Valley, 540-665-0461. Attached, in word format, is a brochure about the workshop.



Conference Registration Form

Name: _____

Organization: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Email: _____

Registration fee for the Conference is **\$15.00**

Please mail check and registration information

to: The Arc of Northern Shenandoah Valley, P.O. Box 3263, Winchester, VA 22604 - *Registration will end July 3rd or when the number of attendees reaches 250. Please register early. Call 540-665-0461 if you need additional information*

Directions to Conference:

from Points North (Martinsburg, WV). Proceed South on I-81. Bear right on ramp at sign reading "Exit 302 VA-627 to Middletown" Southwest. Follow signs to Lord Fairfax Community College.

From Points South (Richmond, VA): Proceed North on I-95. Continue on I-395, Henry G. Shirley Memorial Hwy. Continue on ramp at sign reading "Exit 170B I-495 North to Rockville. Continue on I-495, I-495 Inner Loop, Capital Beltway and go North. Continue on ramp at sign reading "Exit 9A I-66 West to Vienna/Front Royal. Bear right on I-66 and go West. Bear right on ramp at sign reading "Exit 1B I-81 North to Winchester." Continue on I-81 Northeast. Bear right on ramp at sign reading "Exit 302 VA-627 to Middletown" Northeast. Follow signs.

From Points East (Washington D.C.) Proceed on I-395 Southwest. Bear right on ramp at sign reading "Exit 1C I-495 to Rockville" West. Continue on I-495, I-495 Inner Loop, Capital Beltway North. Continue as above (from Richmond).

From Points West: Proceed on US-50 East. turn right on ramp at sign reading "US-11 South/Roanoke" South. Bear right on VA-37. Turn right on ramp at sign reading "I-81 South to Roanoke" South. Bear right on I-81 southwest. Bear right on ramp at sign reading "Exit 302 VA-627 to Middletown" Southwest. Follow signs to Lord Fairfax Com.Col.

The Arc
of Northern Shenandoah Valley
P.O. Box 3263
Winchester, VA 22604

A Statewide National Family Caregivers
Support Program (NFCSP) Conference for
Aging and Developmental Disabilities
Professionals

Developing COLLABORATIVE STRATEGIES For Assisting Aging Family Caregivers & Aging Individuals with Developmental Disabilities



The Arc of Northern Shenandoah Valley and
The Arc of the United States
present **Matthew P. Janicki, Ph.D.**
and **DiAnn Davies Baxley, M.A.R.**

Friday, July 11, 2003

9:00 a.m. - 4:30 p.m.

**LORD FAIRFAX COMMUNITY
COLLEGE Special Events Cntr.
173 Skirmisher Lane
Middletown, Virginia**

Agenda

- 8:30 Registration**
- 9:00 Introductions and Welcome**
- 9:30 Overview of Developmental Disabilities and Aging Systems**
- Demographic and population issues
 - Aging concerns affecting families
 - Service structures for families and carers
- 10:30 Networking/Break**
- 10:45 Overview of NFCSP**
- Concerns of families, grandparents and other carers.
 - Virginia's implementation of NFCSP
- 12:00 - 12:45 Lunch and Video Preview**
- 12:45: Supports for Families and People with Developmental Disabilities**
- Financial supports, legal issues
 - Using Medicaid & other resources
 - The aging network and NFCSP
 - Building coalitions & networks
- 2:15 Networking/Break**
- 2:30 Accessing Local Resources**
- VA Coalition for Aging & DD
- 3:30 Local County Network Building**
- 4:15 Wrap-up and Adjourn**

The Arc of the United States

The Arc of Northern Shenandoah Valley and the Aging Family Caregiver Support Project

In 2000, Congress created a new caregiver support component to the Older Americans Act called The National Family Caregiver Support Program (NFCSP). The NFCSP is designed to help family members provide care for their aging relatives at home and to aid older parents who are the primary carers of persons with developmental disabilities. The NFCSP also supports grandparents raising grandchildren with intellectual and developmental disabilities.

The NFCSP calls for each state, working in partnership with its area agencies on aging and local community service providers, to provide supports for family caregivers.

The most effective supports are those that fully reflect the complexity of a family or individual's situation. Professionals in the aging and developmental disabilities fields have been successfully collaborating on behalf of people with development disabilities for a number of years. The NFCSP offers the opportunity for further collaboration to help aging individuals with developmental disabilities and their caregivers better access services.

The workshop also offers an opportunity to explore the issues, study what has worked, and learn about new opportunities presented by the NFCSP. Participants will be supported in developing local strategies and services that can be provided to help parent caregivers. It is very important, therefore, to ensure that your area is well represented at the conference!!

By the end of the day participants will possess new resources, new strategies, and new partners in addressing the needs of aging families.

Financial support for this workshop was provided by the Administration on Aging through a grant to The Arc/USA.

About The Speakers

DiAnn Davies Esley, B.Sc., M.A., R., Center for Intellectual Disabilities, University at Albany, is one of the core faculty for the NFCSP grant through The Arc of the United States and Training Coordinator for the Center on Intellectual Disabilities at the University. She is the project protocol administrator on a research project focusing on care issues for persons with developmental disabilities and Alzheimer's living in group homes through the University at Albany and University of Illinois at Chicago.

She is a frequent presenter at state, national and international conferences and has authored technical articles, policy guidelines, brochures, and training manuals dealing with various topics on lifelong supports for individuals with disabilities.

Matthew P. Janicki, Ph.D., is research associate professor of human development at the Institute of Disability and Human Development at the University of Illinois at Chicago, and serves as director for technical assistance for the Rehabilitation Research and Training Center in Aging with Mental Retardation at the University. He is also research professor and co-director for the Center on Intellectual Disabilities at the University at Albany (New York). Formerly, he was director for aging and special populations for the New York State Office of Mental Retardation and Developmental Disabilities.

Dr. Janicki was a Joseph P. Kennedy, Jr. Foundation Public Policy Leadership Fellow. He is the author of numerous books and articles in the area of aging, dementia, public policy, and rehabilitation with regard to people with intellectual and developmental disabilities and has lectured and provided training on aging and intellectual disabilities across the world. Dr. Janicki is the past-chair of the United States International Council on Mental Retardation and Developmental Disabilities. He is the chair of the aging special interest research group, International Association for the Scientific Study of Intellectual Disabilities. (IASSIDI).



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau, Human Services Program Coordinator

DATE: May 20, 2003

SUBJECT: National Study of Adult Day Services 2001-2002

The Virginia Department for the Aging has a CD of the National Study of Adult Day Services 2001-2002 conducted by Partners in Caregiving, Wake Forest University School of Medicine (with PMD Advisory Services, LLC and the Senior Research Group of Market Strategies, Inc.). Funded by a \$400,00 grant from the Robert Wood Johnson Foundation, the study involved a census and survey of adult day centers in the U.S. The study produced a national directory of adult day centers and a profile of services, including gaps in the service delivery system.

Attached, please find a copy of the study's Executive Summary. Other parts of the study found on the CD include: Key Findings – National; Key Findings – State; Service Gaps by State; and, Conclusions. If you want information on the study's findings about Virginia's adult day care services, please contact me at 804-662-9340 or Enau@vdh.state.va.us and I will forward the information to you.

CDs of the National Study of Adult Day Services 2001-2002, can be purchased for \$200.00 from Partners in Caregiving, Department of Psychiatry, Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1087. The price of the CD for National Adult Day Services Association (NADSA) members is \$150.00.



National Study of Adult Day Services 2001-2002

Funded by: The Robert Wood Johnson Foundation
Princeton, NJ

Partners in Caregiving: The Adult Day Services Program
Wake Forest University School of Medicine
Winston-Salem, NC

Executive Summary

A National Study of Adult Day Services, conducted by Partners in Caregiving: The Adult Day Services Program (with PMD Advisory Services, LLC and the Seniors Research Group of Market Strategies, Inc.), revolved around three major activities: (1) conducting a census of adult day service providers to determine how many adult day centers exist and where they are located; (2) surveying these providers to determine populations served and services offered; and, (3) identifying gaps in the current service delivery system. The assessment of gaps included analysis of utilization gaps (i.e., where centers exist but are underutilized) and availability gaps (i.e., where no centers exist despite a probable need), illustrating counties that are under served, in equilibrium, or have excess capacity.

The study confirmed 3,407 adult day centers in the United States, of which 53% are well established, having been open for 11-20 or more years. Individuals being served range in age from 18 to 109, with an average age of 72. The two most prevalent conditions are dementia (52%) and 41% frail elderly (age 60+ in need of supervision and/or at-risk of social isolation; no dementia). Twenty-four percent (24%) are diagnosed with mental retardation/developmental disabilities, 23% are physically disabled but cognitively intact, and 14% have a chronic mental illness. Forty-three percent (43%) of individuals enrolled in an adult day center need assistance with toileting, 37% with walking, and 24% with eating.

Twenty-one percent (21%) of adult day centers are based on the medical model of care, 37% are based on the social model of care (with no medical component), and 42% are a combination of the two. Adult day centers provide a vast array of services such as: therapeutic activities, health monitoring, social services, personal care services, meals, transportation, nursing services, medication management, caregiver support services, rehabilitation therapy, medical services, overnight care and emergency respite.

Most people attending an adult day center live with an adult child (35%) or a spouse (20%). The average length of stay at the center is two years, with the number one reason for discharge from the center being placement in a residential setting (such as a long-term care facility). The number two reason for discharge is death.

National Study of Adult Day Services (2001-2002)
Executive Summary
Page 2

The study notes that the majority of adult day centers are not-for-profit (78%), operate under the umbrella of a large parent organization (70%), and are open Monday through Friday, eight or more hours a day. On average, adult day centers serve 25 people per day (with an overall enrollment of 42) at an average cost of \$56/day. The average daily fee, however, is \$46/day (less than cost). Annual revenue (on average) is \$365,208, of which 38% comes from third-party public reimbursements (mainly Medicaid Home- and Community-Based Waiver dollars), 35% from private pay/out-of-pocket payments, 14% from non-operating revenue (such as grants and donations), and 13% from other operating revenue (such as private insurance and ancillary services like transportation).

Growth in the adult day services industry is evident, with 26% of all adult day centers opening in the last five years. However, growth lags behind the need for the service, with 56% of the counties in the United States under served (1,770 counties out of a total of 3,141). The study concludes that the current population base of the United States can support a total of 8,520 adult day centers. With current need not being met, 5,415 new adult day centers are needed nationwide (1,424 in rural areas and 3,991 in urban areas).



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau, Human Services Program Coordinator

DATE: May 20, 2003

SUBJECT: Kinship Care Issues

Please find attached four items pertinent to Kinship Care:

1. An announcement of the October 15, 2003 **Grandrally**. Sponsored by the Children's Defense Fund, AARP, the Child Welfare League, Generations United and the National Committee of Grandparents for Children's Rights, this rally will be held in Washington, D.C.
2. Policy Brief A-59: Foster Children Placed with Relatives Often Receive Less Government Help. Published by Rob Green of the Urban Institute, this document suggests various methods for improving service access for kinship care providers.
3. Policy Brief A-60: Finding Permanent Homes for Foster Children: Issues Raised by Kinship Care. Published by Rob Green of the Urban Institute, this research brief examines the issues surrounding kin adoption.
4. Policy Brief A-61: When Child Welfare Agencies Rely on Voluntary Kinship Placements. Published by Rob Green and Karen Malm of the Urban Institute, this document discusses the various issues social service agencies face in dealing with voluntary kinship caregivers.



WEDNESDAY IN WASHINGTON™ GRANDRALLY TO LEAVE NO CHILD BEHIND®

for
Grandparents and Other Relatives Raising Children

October 15, 2003
9:30 a.m.

West Grassy Front of the United States Capitol
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children whose own parents cannot care for them.
Step forward with these grandparent and other relative caregivers
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Call 202 662 3656
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AARP **AARP®**

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Generations United



National Committee of
Grandparents for
Children's Rights



Generations United Conference, "Uniting Generations to Build a Better World,"
October 15-18, 2003, includes a special track on grandparents raising grandchildren.
Contact: 202 638 1263 or www.gu.org for more information.



Foster Children Placed with Relatives Often Receive Less Government Help

Rob Geen

Everyone breathes a sigh of relief when there's relatives available, but they don't get enough attention. They're a little lower on the list because their case is more stable. Relatives don't call us and complain because they want to keep the kid and they're committed.

—a California foster care supervisor

Sometimes they don't know if it's okay to ask. Sometimes they are scared because they think we'll think they can't do it [care for a child].

—an Indiana child protective services worker

Child welfare agencies are responsible for ensuring that the children they place in foster care are cared for appropriately. Agencies may provide or refer children to a variety of services to meet their needs, including services that address issues arising from the abuse or neglect they suffered. Agencies also provide a variety of supports to foster care parents in their effort to care for children.

While child welfare agencies traditionally work with foster parents caring for children with whom they have no prior connection, over the past 15 years agencies have begun to rely increasingly on relatives or people who have a close emotional bond to an abused or neglected child to act as foster parents. Today, almost all child welfare agencies consider kin the first placement choice when foster care is needed, and approximately one-third of all children in foster care are in kinship care. Kinship foster parents differ from non-kin foster parents in several ways that may influence the services they, and the children they care for, need from child welfare agencies.

Kin are often not “prepared” to care for children. Unlike traditional foster parents,

kin typically have not been licensed as foster parents or attended training on what it means to be a foster parent before receiving a foster child. Kin are also typically not physically prepared to take on parenting responsibilities. They may not have many things needed to care for children, including a crib or bed, car seat, and toys. Many kin are also not emotionally prepared for their new roles. Since most kin are grandparents, in addition to assuming new parenting responsibilities, they must acknowledge the failure of their own children to parent effectively.

Kin typically have no experience with child welfare agencies. Unless they have been a foster parent before, kin typically do not understand the child welfare system. They do not know what to expect from the child welfare caseworker and the courts. They may also mistrust or fear the child welfare system.

Kin themselves may face many challenges that most non-kin foster parents do not. Research has consistently shown that kinship foster parents are more likely to be single, poorer, older, and have less formal education than non-kin foster parents (Ehrle and Geen 2002). While evidence is mixed, some studies have found that kin are more likely than non-kin foster parents to be working. Kinship foster parents also more often report being in poor health.

State policies indicate that kin are generally eligible to receive the same services as non-kin foster parents (Jantz et al. 2002). However, past research has clearly shown that in practice, kin foster parents and the children in their care receive fewer services. Kin are offered fewer services, request fewer services, and receive fewer of the services they request (Barth et al. 1994; Berrick, Barth, and Needell 1994; Chipungu and Everett 1994; Chipungu et al. 1998; Cook

Despite kin's greater needs, they are offered fewer services than non-kin foster parents, request fewer services, and face barriers to accessing services.

This brief encapsulates findings from *Kinship Care: Making the Most of a Valuable Resource*, an upcoming UI Press book edited by Rob Geen. *Kinship Care* is scheduled for release in late 2003. For more information about this title, please visit <http://www.uipress.org>.

Kin caregivers often need counseling services to help them deal with birth parents, their own feelings about parenting again, and their new relationships to their related children.

and Ciarico 1998). At the same time, past research has not identified reasons for this disparity.

This brief examines how local child welfare agencies serve kinship foster care families. We confirm that, despite kin's greater needs, they are offered fewer services than non-kin foster parents, they request fewer services of caseworkers than non-kin foster parents, and they face barriers to accessing services. Moreover, we identify a number of reasons—some related to caseworkers, some to kinship caregivers, and others to agency policies—that explain why kin often do not receive needed services. Findings in this brief are based on intensive case studies of local kinship care policies and frontline practices conducted by the Urban Institute during the spring and summer of 2001 in 13 counties in four states—Alabama, California, Connecticut, and Indiana.¹

Kin Often Have Different Needs than Non-Kin Foster Parents

In all of our study sites, workers, administrators, and kinship foster parents documented that kinship care families often have different needs than non-kin foster families. Their different needs stem from the fact that compared with non-kin foster parents, kin are more likely to be poor, working outside the home, older, less educated, unprepared for their new caregiving role, and isolated from others in the community. Workers also noted that since many kin try to take care of things without child welfare assistance, when they do ask for help they are often in a crisis situation. Thus their needs are more immediate and intense. Workers also pointed out that kin are a very heterogeneous group and have varying needs depending upon individual circumstances.

According to workers, the starkest difference between kin and non-kin foster parents is the level of financial assistance needed by kin. Few non-kin foster parents are poor. In most states, sufficient income is a foster care licensing criterion. However, kin are often in financial distress or just getting by. And this is before they take on the responsibility of caring for a child.

In addition to income differences, workers noted that kin are more likely than non-kin foster parents to need child care assistance. Non-kin foster parents are more likely to be married and often at least one

parent is not working full-time outside the home. Thus, non-kin foster parents often have less need for child care assistance.² Most kin are single and work outside the home. Given their already tenuous financial situation, kin have great difficulty locating child care they can afford. In several locations we visited, workers noted that they would open or keep open a child welfare case mainly as a way to secure child care assistance for kin.

Another key difference between kin and non-kin foster parents is their relationship with the birth parents of the children they are caring for. Kin caregivers often need counseling services to help them deal with birth parents, their own feelings about parenting again, and their new relationships to their related children.

Because kin are often older and not well-educated, workers and kin noted that they need more support in meeting children's educational needs and providing recreational opportunities. Several kin noted it was hard for them to assist children with their homework and they wanted to get tutoring help. Other kin questioned whether they were doing a good job as a foster parent, because their age limited what they could do with the children. Because of their age and lack of transportation, kin are often isolated from others in the community, according to caseworkers. While non-kin often interact with other foster parents through foster parent associations, kin have only recently been encouraged to participate in such groups.

Kin Are Offered Fewer Services

In each of the sites we visited, caseworkers, supervisors, and administrators acknowledged that kinship foster parents are typically offered fewer services. Many workers noted that they offer few services to kin and non-kin foster parents unless there is an obvious need. If foster parents do not ask for help, many workers assume that they are doing fine. Many workers noted that they spend most of their time handling crises, thus they have little time to assist foster parents who do not complain or seek out assistance.

Other workers commented that they tend to have higher expectations for kinship foster parents. Because kin know the child in their care and have an emotional bond with that child, workers sometimes assumed that the kin would take good care

Because kin do not always complete the same licensing process as non-kin foster parents, kin may not receive or even be eligible for a variety of services.

of the child and did not need agency assistance. Workers know that kin will continue caring for children even without close attention from the agency, and thus feel less obligated to assist kin.

Several workers who reported offering fewer services to kin were concerned about kinship foster parents becoming dependent upon the public agency services and support. These workers argued that their job was to help kinship caregivers become self-sufficient. Some workers felt that kin tried to exploit the system to get additional support.

Kin may also be offered fewer services than non-kin foster parents because they are rarely recruited by private foster care agencies. In many states, child welfare agencies contract with private Family Foster Care Agencies (FFAs) to recruit, license, monitor, and support foster parents. Many workers noted that FFAs provide greater support than the public agency can, both financial support as well as services. But workers said that very few kin are part of FFAs. Many of the services that kin reported having difficulty accessing from community providers are provided to non-kin foster parents directly through FFAs.

Kin Request Fewer Services

While child welfare workers and administrators agreed that the agency typically offered fewer services to kin, they also agreed that kin generally request fewer services than non-kin foster parents. Workers suggested that the reasons kin tend not to request many services include not knowing what is available, fear of the agency, and kin's feelings that they do not need or want agency assistance.

Many workers reported that kin are often not open to agency assistance, because they either did not feel services are needed or simply have a "take care of my own" attitude. Other workers noted that kin's pride stepped in the way of their requesting help from the agency. Kin may be reluctant to admit to themselves that they need assistance.

Many workers commented that kin often do not understand what they are getting themselves into. They think they will be caring for a child for a short period of time and that they can handle it. They do not always focus on the needs of the child and the costs associated with caring for the

child, especially if the child is not returned home quickly.

Moreover, because kin lack experience with the child welfare system, they are often not aware of services that may be available and are thus less likely to request these services. As mentioned earlier, unlike non-kin foster parents, kin rarely are part of foster parent associations, a key source of information about what services may be available.

Workers reported that kin also request fewer services because they may be seeking to avoid agency contact. Some kin intentionally hide information from agency workers, especially information related to the birth parent, because they do not want to do anything that may jeopardize the birth parent's ability to get the child back. Other kin hide information from caseworkers because they do not want the intrusion of the agency, preferring to handle the situation privately.

Workers also reported that many kin are afraid to ask for assistance, believing that if they ask for assistance, the agency will conclude that they are not capable of caring for the child. Kin also may not be very assertive in asking for assistance because they fear the agency will view them as difficult.

Kin Face Barriers to Accessing Services

Even when kin request services or workers seek to offer services, kin may have difficulty accessing the services they need. Kin are not eligible for a variety of services or have difficulty completing applications for assistance. Kin often have difficulty finding services available from community agencies. Workers who wanted to help kin obtain support often reported having difficulty assisting them. Workers noted that kin often have to wait a long time to obtain the supports they need.

Because kin do not always complete the same licensing process as non-kin foster parents,³ kin may not receive or even be eligible for a variety of services. In addition to a monthly foster care payment, foster parents are automatically provided a variety of services including health insurance for the children they care for; payment of health-related services not covered under insurance; vouchers for clothing, school supplies, or other specific needs; and child care and respite care assistance. In many

Both caseworkers and kinship caregivers could benefit from additional training.

states, kin who are not licensed foster parents are denied foster care payments and instead may have to apply for financial support through the welfare office. Not only are the welfare payments significantly less than the foster care payments, but also many kin are either not eligible for the payments or have difficulty obtaining support.

Kin may not be eligible to receive other services or supports that are available to non-kin foster parents depending upon the local child welfare agency. For example, workers in Alabama noted that children being cared for by kin receive Medicaid, which does not pay for some needed items. The child welfare agency pays for these expenses when children are in non-kin foster care, but not if they are placed with kin. In one local office in California, administrators noted that respite care services are available to non-kin but not kin foster parents, and in another local office workers noted that obtaining day care for kin was problematic.

One of the main barriers to kin accessing services is knowledge; because most kin lack experience with the child welfare system, they do not know where to look for or how to access community resources. Workers in several states noted that a key problem for many kin foster parents is finding doctors who accept Medicaid. While non-kin foster parents face the same problem, many have developed relationships with doctors who accept Medicaid. In one California local office, both kin and non-kin receive health insurance for their foster children, but kin who do not receive foster care payments receive health insurance through a managed care organization that makes it more difficult to access services.

Even when workers try to help kin access services, kin may not be as successful as non-kin foster parents. Based on information collected from workers in many sites, many workers do not understand the eligibility requirements for services provided by other agencies. Many workers were frustrated that they themselves did not know the services available to foster children. They noted that in some cases experienced foster parents know more than they do.

Kin also have difficulty accessing services when they need them. Workers and kin reported that the wait for services can be long and place a considerable burden on kin during the waiting period. This is particularly true for services linked to licensing. Unlike non-kin foster parents, kin are

typically not licensed when they begin caring for a child and the licensing process can take two months to a year or even longer.

Summary and Discussion

We found almost unanimous consensus (from administrators, supervisors, workers, judges, and kin) that kinship foster parents receive fewer services for the children in their care than non-kin foster parents despite having greater service needs. While there are a number of subtle differences across states and localities for why kin receive fewer services, for the most part, there are a few key reasons that were true for all sites we visited.

- **Workers offer fewer services to kin than to non-kin foster parents.** Some workers acknowledged that they have higher expectations of kin or that they do not want kin to become dependent upon the public agency. However, most workers acknowledged that, for a variety of reasons, the agency was simply failing to adequately meet the needs of kin.
- **Kin request fewer services of caseworkers than non-kin foster parents.** Kin do not know what to ask for, are afraid to ask out of fear of appearing unable to care for a child, or may simply want to avoid public agency intrusion.
- **Kin face barriers to accessing services.** Kin are often unable to obtain support when they seek it out because of eligibility constraints, lack of familiarity with community resources, or waiting lists for services.

These findings suggest that both caseworkers and kinship caregivers could benefit from additional training. Caseworkers acknowledged that working with kin was in many ways different than working with non-kin foster parents, yet few had received any information or training on how to approach kinship caregivers differently. Workers also admitted to having limited knowledge of community resources, often relying on non-kin foster parents for information to advise kinship caregivers. Moreover, many workers appeared confused about the eligibility criteria and the application process for a variety of public services which kin are eligible to receive.

Unlike with non-kin, many child welfare agencies do not require kinship caregivers to complete any formal training to be a foster parent. Since kin are caring for a specific child they already know, they may

When support is linked to licensing, many kin will fail to receive support since many are not licensed.

not need to complete the exact training that non-kin foster parents complete. However, it seems obvious that kin could use training in a variety of areas related to service delivery, including what services are available from the child welfare agency, other public services kin may be eligible for and how to apply, and services available from community agencies.

Child welfare agencies may also want to examine their policies to determine if kin are inadvertently being denied services they may need to help care for a child. When support is linked to licensing, many kin will fail to receive support since many are not licensed, and those that are seeking licensure may take considerable time to complete the licensing process. Workers also identified a need for greater clarity in child welfare agency policies about the services that may be available for kin.

Child welfare agencies should also experiment with new approaches to engage kinship care families. Family group conferencing programs (also called family group decisionmaking) that bring the entire family network together to plan for the care of a child appear to be a promising approach that many agencies have implemented. Agencies may also want to explore ways to bring kinship foster parents together more. In many localities, experienced foster parents are recruited to mentor new non-kin foster parents. This approach may also work well with kinship foster parents. In addition, non-kin foster parents benefit greatly from participation in foster parent associations. Increasingly, child welfare agencies are helping to develop kinship caregiver support groups. Support groups can not only provide an opportunity for kin to share experiences with one another, they can also be an effective approach for educating kin about the child welfare system and services available to them.

Foster children can benefit from the love and commitment of kinship caregivers and from a sense of belonging and permanency. However, these children still experience the trauma of being separated from their parents. Whether they are placed with kin or non-kin foster parents, foster children require considerable support. Child welfare agencies need to reflect on the uniqueness of kinship care arrangements and develop strategies to ensure that kinship caregivers have the necessary knowledge and resources to best care for children entrusted to them.

Notes

1. Alabama: Jefferson (Birmingham), Mobile, and Taladega Counties; California: Los Angeles, San Diego, Santa Clara (San Jose), and Santa Cruz Counties; Connecticut: Bridgeport, Hartford, and Torrington Counties; and Indiana: Lake (Gary), La Porte, and Marion (Indianapolis) Counties.
2. At the same time, workers noted that child care was becoming more of an issue in recent years for non-kin foster parents as well because there are more non-kin foster families with two working foster parents.
3. See Jantz et al. (2002) for a complete discussion of state policies for licensing kin as foster parents.

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About the Author



Rob Geen is a senior research associate in the Urban Institute's Population Studies Center, specializing in child welfare and related child, youth, and family issues.



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This series is a product of *Assessing the New Federalism*, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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This series is dedicated to the memory of Steven D. Gold, who was codirector of *Assessing the New Federalism* until his death in August 1996.

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Kinship care has a far-reaching impact on child welfare agencies' permanency planning efforts and the permanency outcomes of foster children.

This brief encapsulates findings from *Kinship Care: Making the Most of a Valuable Resource*, an upcoming UI Press book edited by Rob Geen. *Kinship Care* is scheduled for release in late 2003. For more information about this title, please visit <http://www.uipress.org>.

Finding Permanent Homes for Foster Children: Issues Raised by Kinship Care

Rob Geen

I think sometimes bio[logical] parents are not pushing for reunification as strongly because the child's with family, they think 'I can see the child whenever I want, I know the child's taken care of when they're with grandma.' And it almost gives [birth parents] permission to go and continue their behavior and not straighten out what created the problem to begin with because they know the child's with family and they're perfectly content with that and comfortable.

—Connecticut administrator

Most kin are willing to adopt. Some that apply for the guardianship program only do so because that is what they have been told is available. Court people speak with the families and often find out that the agency worker has never even discussed adoption with them.

—Indiana court official

One of the primary goals of our nation's child welfare system is to ensure that children who have been removed from their parents' homes are reunified or placed in another permanent situation (i.e., adoption or legal guardianship) in a timely manner. Research shows that children placed with foster parents who are related to them (kinship foster care) tend to remain in foster care significantly longer than children placed in non-kin foster care (Cook and Ciarico 1998; Courtney 1994). Compared with children placed in non-kin foster care, children placed with kin are less likely to be reunified with their parents (AFCARS 1998; Berrick, Needell, and Barth 1995; Testa 1997) and less likely to be adopted (Berrick and Needell 1999; Berrick et al. 1995).

Some research indicates that kinship foster parents are reluctant or unwilling to adopt children in their care (Gleeson 1999; Thornton 1991). However, other studies show that if they are properly informed, the majority of kin are willing to consider adoption (Beeman et al. 1996; Testa 2001; Testa et al. 1996; Zimmerman et al. 1998). Several studies document that child welfare agencies and workers approach kinship care differently with kin than non-kin foster parents. Studies indicate that workers believe that kin see adoption as unnecessary, and even when kin may be willing to adopt, caseworkers often fail to speak to them about the option of adopting (Beeman and Boisen 1999; Beeman et al. 1996; Berrick, Minkler, and Needell 1999; Chipungu et al. 1998; Thornton 1991).

In recent years, many states have implemented subsidized guardianship programs, providing kin with an alternative to adoption that provides ongoing financial assistance similar to the subsidies offered to people who adopt special-needs children from foster care. Data from a 2001 Urban Institute survey indicate that 35 states had implemented subsidized guardianship programs (Jantz et al. 2002).

This brief examines how local child welfare agencies approach permanency planning with children in kinship foster care and why kinship foster parents may be reluctant to adopt or take legal guardianship of relative children in their care. We find that child welfare agencies often pursue permanency less vigorously when children are placed with kin. We also find that

Although long-term foster care is generally discouraged, it is a common permanency outcome when children are placed with kin.

birth parents are significantly less motivated to complete case plan requirements when their children are placed with kin. In addition, guardianship as opposed to adoption is the most common permanency outcome as well as the outcome most stressed by caseworkers. Most relatives we spoke to said they were willing to adopt. However, there are many reasons, including financial disincentives, why kin may not be willing to adopt. Findings in this brief are based on intensive case studies of local kinship care policies and frontline practices conducted by the Urban Institute during the spring and summer of 2001 in 13 counties in four states—Alabama, California, Connecticut, and Indiana.¹

Kinship Care Alters the Permanency Planning Process

Administrators and workers reported that permanency planning is different when children are placed with kin. When children are placed with non-kin and reunification is ruled out, workers seek termination of parental rights (TPR) and then adoption. When children are placed with kin, TPR is often seen as less necessary and adoption is not viewed as the only acceptable or even preferred permanency option. In some sites, child welfare agencies often help arrange a transfer of custody from the birth parent to the kinship caregiver and consider this a permanent outcome. Allowing children to remain in long-term foster care is generally prohibited when children are placed in non-kin foster care. Although long-term foster care is discouraged for children in kinship foster care as well, administrators and workers reported that it is a common permanency outcome when children are placed with kin.

The extent to which agencies encourage kin to adopt varies greatly depending upon the local office, the individual caseworker, and the specific child. In all the sites we visited, kin may become legal guardians instead of adoptive parents of the foster children in their care. Moreover, in almost all the sites we visited, respondents noted that kin more often take guardianship than adopt. Agency workers push kin to adopt most when they are caring for young children. Workers did not feel that they push

kin too hard and noted that they rarely, if ever, threaten to remove a child if the kin will not adopt. Many kin, however, said they felt pressured to adopt. Other kin noted that they would be willing to adopt but that this option was never offered. Workers reported that they often assume kin will not be interested in adoption and thus it is not even discussed. In addition, workers, administrators, judges, and kinship caregivers all noted that when child welfare agency staff do discuss adoption with kin, they do a poor job of explaining how adoption differs from guardianship.

Many administrators, workers, and judges noted the problem of relatives who are identified late in the process when a child has bonded with a non-kin foster parent who is willing to adopt. Different judges have different perspectives on whether to give preference to these relatives. Most argue that relatives should not be punished due to the failure of the agency to identify them and will still give them preference. Others question why the relatives were unaware of the child's situation. Workers expressed similar concerns of the intentions of relatives who show up late in the process. Some questioned whether the relatives would simply give the children back to the birth parents. Overall, workers and administrators noted that this is an area where specific policies are lacking, prompting case-by-case decisions.

Kinship Care May Reduce Birth Parent Motivation

We found overwhelming consensus from administrators, workers, and kinship caregivers in every site we visited that birth parents are less motivated to meet case plan goals required for reunification when children are in kinship care. Many reasons were offered for birth parents' lack of motivation. When children are with kin, birth parents tend to have much greater access to their children. They can typically visit or call their children frequently, when they want (as opposed to at a scheduled time), and where they want (as opposed to at the child welfare office or a visitation center). Many kinship caregivers noted that birth parents are happy to have their freedom back and to pass along the responsibilities

Birth parents are significantly less motivated to complete case plan requirements when their children are placed with kin.

of parenthood. This is particularly true of substance-abusing parents who can continue their addiction without being concerned with how it affects their children.

Many caregivers also commented that birth parents do not feel shame when their children are placed with kin. Many children are raised by relatives and this has less stigma associated with it than having children raised by foster parents. Birth parents are typically less likely to fight a transfer of custody or even TPR when children are with kin. In fact, workers suggested that birth parents may welcome TPR and permanency so that the agency is out of the picture.

Kin May Be Willing but Face Disincentives to Adopt

In contrast to some prior research and the commonly held perception, the majority of kin we spoke to were willing to adopt. Workers reported that aunts and uncles are much more likely than grandparents to adopt and that all relatives are more likely to adopt young children. Some grandparents feel it is unnatural to become a child's legal parent when you are already the child's grandparent. Some older grandparents are reluctant to adopt because they do not know what will happen to their health as they and their kids get older. Workers and kinship caregivers agreed that the agency does not do a good job of explaining the differences between adoption, guardianship, and long-term foster care. Many kin do not see guardianship as different from adoption.

There are a variety of other reasons why some kin may be disinclined to adopt. Some kin feel that adoption punishes the parent too much. Many kin hold out hope that parents will eventually get better. Some kin see taking guardianship as a challenge to parents to get their kids back. Other kin fear that adoption will push already troubled birth parents over the edge. If kin have a good relationship with birth parents, they will do anything not to upset this relationship, including refusing to adopt. Workers reported that birth parents fight guardianship less than TPR and adoption and this is why many kin refuse to adopt. Many kin fear that adoption will not only upset the

birth parent, but also cause a rift among the larger extended family.

One major incentive that workers and kinship caregivers noted for pursuing guardianship is that the process is much quicker than TPR and adoption. At the same time, while many kin want the child welfare agency out of their lives, many others want the agency to stay involved. Kin may be concerned about the long-term needs of the children in their care and accessing needed services following adoption. Kin noted that they want the court to remain involved so that the child welfare agency will continue to help them. Some kin expressed fear of being legally responsible for the actions of children with severe behavioral problems.

Depending upon the state and the specific child and family circumstances, there may be a variety of financial disincentives for kin to adopt or take guardianship. Some kin are not eligible for subsidized adoption or guardianship. In addition, kin often receive greater support if they choose long-term foster care or guardianship instead of adoption.

Some kin who can pass the licensing requirements to receive foster care payments cannot pass the requirements for subsidized guardianship or adoption or do not meet eligibility requirements. For example, in Connecticut, there is no drug screening for kin to become foster parents, but there is for subsidized guardianship and adoption. Interestingly, kin are still permitted to take guardianship or adopt if they fail a drug screen, but are not eligible to receive a subsidy. Workers in California noted that the criteria for adoption are more stringent than the foster parent licensing standards and thus kin who are licensed foster parents may not be able to receive adoption subsidies. In both Indiana and Connecticut, only blood-related kin (i.e., not godparents or other family friends) can receive a guardianship subsidy. And in Indiana and California, kin may only receive guardianship subsidies if they care for young children or a sibling group. In Alabama, state law prohibits kin from receiving an adoption subsidy, and the state has no subsidized guardianship program.²

In addition to the barriers to accessing an ongoing monthly subsidy, kin in

Child welfare agencies may want to rethink how they approach permanency planning for children in kinship care.

Alabama, California, and Connecticut may also lose access to other financial supports and services if they adopt or take guardianship. For example, kin who adopt or take guardianship may not receive clothing allowances, school supplies, free summer camp, or other miscellaneous supports the agency provides for children in foster care. In Connecticut, foster children receive free college tuition. Kin who take guardianship receive similar tuition assistance for the children in their care but are not eligible if they adopt. Workers in Connecticut also noted that kin caregivers' income is not considered for Supplement Security Income (SSI) benefits for a child if kin take guardianship, but their income is considered if they adopt. SSI benefits are considerably more than basic foster care or adoption assistance subsidies. Similarly, workers in California pointed out that kin who become guardians of foster children are eligible for a basic foster care rate, but not a specialized rate. Many kin care for foster children with special needs and receive specialized foster care payments that may be two or three times the basic foster care rate. Workers in California also noted that kin receive child care assistance as long as the agency maintains an open case, but if kin adopt or take guardianship and a case is closed, they are no longer eligible for such assistance.

Summary and Discussion

Kinship care has a far-reaching impact on child welfare agencies' permanency planning efforts and the permanency outcomes of foster children. While long-term foster care is discouraged, workers feel much less urgency to terminate parental rights, close a case, or push for adoption when children are living with kin. Birth parents may also feel less urgency to take the necessary steps for reunification when their children are placed with kin. Kinship foster children are also less likely to be adopted. Many agencies do not encourage kin to adopt and others do a poor job of explaining the need for adoption or how adoption differs from other permanency options. While we find that kin may be less opposed to adoption than previously thought, they may have legitimate reasons and financial incentives for not wanting to adopt.

While most people acknowledge that adoption is more permanent than guardianship or long-term foster care, few sites are making a strong push to have kin adopt the children in their care. Many workers do not think adoption is necessary for children cared for by relatives, while others do not think many kin would consider adoption. If all things were equal, workers generally agree that most kin would consider adoption. But things are typically not equal. Workers acknowledge that kin are very concerned about how adoption would affect their relationship not only with the birth parents, but also the child's extended family. Moreover, many kin would lose considerable financial or other supports if they chose to adopt.

Permanency may be conceptually appealing to plan and strive for, but it is very difficult to measure. Although we can assess how stable arrangements are, a child's perception of permanency is also critical. Do children in kinship care feel that their living arrangement is less permanent if their caregiver does not adopt them? Do kin feel a greater sense of commitment to the children if they adopt? And while we can measure the stability of placements, research is severely limited on how the stability of children in long-term foster care and guardianship differs from those who have been adopted.

It appears nonsensical to deny ongoing financial assistance to relatives who cannot meet subsidized adoption or guardianship requirements, yet still allow these same kin to permanently care for children. If kin caregivers are acceptable adoptive parents, they should be acceptable subsidized adoptive parents. If not being able to meet requirements means that kin are somehow not acceptable caretakers, then they should not be permitted to have permanent custody. If they are acceptable caretakers, then they should not be denied ongoing financial support—such denial only serves to punish the children.

This discrepancy points to the larger issue of the inconsistencies in requirements and support provided by different permanency options available to kinship caregivers. Child welfare agencies may want to rethink how they approach permanency planning for children in kinship care.

Agencies may want to experiment with methods to better assess kinship caregivers' commitment as well as how children in kinship care feel about the permanency of their living arrangement, rather than focusing solely on legal permanence. Both the adoption and the guardianship process are difficult for kin (not to mention workers) to understand, and kin may simply get hung up over the word adoption. Agencies need to do a better job of articulating how a legal change in permanency affects the responsibilities of the kinship caregiver and the rights of the birth parents. Agencies may want to work with their state courts to design a permanency option that is sensitive to concerns of kinship caregivers but allows for greater stability than guardianship. In addition, greater commitment to permanence, regardless of how it is measured, should not be rewarded with less assistance.

Notes

1. Alabama: Jefferson (Birmingham), Mobile, and Taladega Counties; California: Los Angeles, San Diego, Santa Clara (San Jose), and Santa Cruz Counties; Connecticut: Bridgeport, Hartford, and Torrington Counties; and Indiana: Lake (Gary), La Porte, and Marion (Indianapolis) Counties.
2. Administrators report being able to license some kin as foster parents and offer them adoption assistance as foster parents, but note that this is uncommon.

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This series is dedicated to the memory of Steven D. Gold, who was codirector of *Assessing the New Federalism* until his death in August 1996.

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When Child Welfare Agencies Rely on Voluntary Kinship Placements

Karin Malm and Rob Geen

Child welfare agencies must determine whether to treat kinship care as an extension of the biological family, or as a type of temporary substitute care.

The first issue is safety; [we] have to take the child if there's any risk. One case I've done recently, the mom is using [drugs] and she admits she's using, she goes into detox [substance abuse treatment] and detox knows she has kids so they call it in to us. We go there and ask, 'Who is taking care of your kids?' The mom put the kids with grandmother and has no prior history with the department. We can take the kids into custody for neglect but what's that going to do? She's in treatment already and the kids are safe.

—Connecticut investigative worker

If [the child] can be safe in his own home or with a relative, there would be no need for custody care. If we make a recommendation for the child to go with a relative, the relative usually gets custody in the court hearing.

—Alabama investigative supervisor

At times, child welfare agency staff may help arrange for a child to live with a kinship caregiver but not ask that the court place the child in the custody of the state. During or after a child protective services investigation, a caseworker may suggest that a parent place a child with a relative; the parent and the relative know that if the parent refuses, the agency may petition the court to obtain custody. We refer to these arrangements as voluntary kinship care placements. Many child welfare experts argue that voluntary kinship care placements are common; data from the 1997 National Survey of America's Families (NSAF) estimate that 300,000 children are in such care. In addition, the largest group of children living with kin are doing so privately; that is, there is no child welfare agency involvement. Many private kin caregivers may at some point seek assistance from child welfare agencies,

and agency responses to such inquiries vary greatly.

Although not taken into state custody, children in voluntary and private kinship care are vulnerable. Thirty-one percent of children in voluntary kinship care and 43 percent of children in private kinship care live in families with incomes less than the federal poverty level. The socioeconomic risks faced by children in voluntary and private kinship care are significantly higher than children overall and are comparable to the risks faced by children in kinship foster care (Ehrle, Geen, and Clark 2001).

This brief looks at when and how child welfare agencies rely on kin to care for children who are not taken into state custody. Our study results confirm earlier research that child welfare agencies encourage and help arrange for kin to care for children without taking the children into custody. Although child welfare staff may suggest placing a child voluntarily with kin and may even assess the kinship caregiver, it is important to note that the arrangement occurs at the discretion of the birth parent and the kin. Findings in this brief are based on intensive case studies of local kinship care policies and frontline practices conducted by the Urban Institute during the spring and summer of 2001 in 13 counties in four states—Alabama, California, Connecticut, and Indiana.¹

Several states, including Alabama, prefer voluntary placements whenever possible. Seven states,² including Alabama, rely on voluntary arrangements for a majority of the children they place with kin. Other states use voluntary placements under more limited circumstances. When and how often child welfare workers rely on voluntary kinship care varies greatly across states and, to a

This brief encapsulates findings from *Kinship Care: Making the Most of a Valuable Resource*, an upcoming UI Press book edited by Rob Geen. *Kinship Care* is scheduled for release in late 2003. For more information about this title, please visit <http://www.uipress.org>.

*When and how often
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lesser degree, among counties within a state, among offices within a county, and among individual workers.

Under What Circumstances Do Voluntary Placements Occur?

There are many circumstances under which child welfare agencies may arrange for a child to live with kin without seeking custody. In many cases, the risk to the child is not enough to meet the agency standards of an official case opening, court involvement, and formal removal of the child from the home. But caseworkers may still have concerns about the safety of the child if he remains with his birth parent. In other situations, such as when a parent enters inpatient substance abuse treatment or begins a jail sentence, there is no parent with whom the child can remain. In these cases, child welfare is often notified by the treatment facility or by law enforcement. Practices vary across states on the use of voluntary placement arrangements in these situations.

Except in Alabama, respondents in our study states noted that the level of risk necessary for legal intervention is central to the decision to arrange or use voluntary placement arrangements. Voluntary placements occur when there is not enough evidence for legal removal of the child or where the abuse is difficult to prove but the agency still has concerns about the situation. Alabama differs from the other three study states in that if a relative is available and can care for a child, the child would not be taken into custody. Most children removed from their homes and placed with kin are in voluntary placements in each of the Alabama sites we visited. Respondents in Alabama still noted risk to the child as a determining factor. However, when Alabama workers discussed risk, they were focusing on the risk to the child in the relative's home (i.e., relative unable to protect from offending parent), not whether the abuse or neglect allegation necessitated legal intervention. Central to caseworker practice in Alabama is an agency philosophy that keeping families out of the system is better for them—a less is more approach.³

In the other three study states, while some respondents in local offices maintained a philosophy that keeping children out of the system is better for families, it was not an agency-wide philosophy.

Empowering families to make their own decisions was noted by some workers in these states as a factor in whether voluntary placements are arranged. Workers said that even if a report of abuse and neglect was substantiated, they may accept a voluntary agreement between birth parent and kin if the ongoing risk is low. If parents, early on in the process—that is, before or during an investigation—are cooperative and suggest that a relative can take the child while they seek help, many workers would agree to such an arrangement.

Some respondents noted that their agency is doing more voluntary agreements because it has become more difficult to prove abuse occurred. There is also some indication that agencies would like to do more voluntary placements and often explore the possibility. Many agency workers noted that most families are not able to reach agreements among themselves. Agencies that use family group conferencing, a technique that involves the entire family in planning for the care of a child requiring protection, reported that family meetings may increase the use of voluntary placements. A court official in California noted that family group conferences mean that many families never come into court because they work out an arrangement among themselves. Other agencies noted that negative media attention has made their agencies more risk-averse and that they cannot rely on voluntary placements as much as they had been.

A lack of agency resources was both an incentive for making informal placements and a reason for not making such placements. In agencies where foster care case-loads were high and resources low, workers suggested that voluntary placements may save foster care resources for those children most in need. At the same time, agencies vary in the extent to which they have resources for children not in state custody. In some agencies, workers noted that the only way to get kin the support they needed to care for a child was to take the child into custody.

It is clear from discussions with workers in Alabama that their use of voluntary placements extends to all children regardless of age or type of abuse or neglect. In the other states, older children are more likely to be placed with a relative in a voluntary placement arrangement. Many workers noted case examples involving

Similar to the decision on whether to use kin voluntarily, workers are following unwritten rules to determine how to support and supervise them.

teenager–parent conflicts that led to voluntary kinship placements. Besides a child’s age, other case characteristics, such as why a child needs protection, affect the decision to suggest a voluntary placement. For example, voluntary placements are more common when a child needs to be placed due to a parental incapacity or other non-abuse-related reason. The relationship between the birth parent and kin caregiver is also a factor in deciding whether to open a case or take custody of a child. Workers noted having to open cases when kin do not get along with, or are scared of, birth parents.

Workers are often involved not in arranging a voluntary placement, but in assessing a placement that was arranged by a birth parent or the police. It is not uncommon for the police to arrange for a relative to temporarily care for a child and then report the family to child welfare. In these situations, child welfare agencies are asked to assess the relative’s home. Similarly, workers may begin a child abuse investigation and find that the child in question has already moved into the home of a relative. Many workers feel their hands are tied in such situations—they cannot remove the child from the relative because they cannot prove the child is in danger.

What Happens after Placement?

The level and nature of ongoing attention paid to voluntary kinship care placements varies significantly based on the risk of the placement and the availability of supportive resources. In Alabama, workers use voluntary placements for higher-risk situations than in other states but almost all are opened as active child protection cases receiving ongoing supervision and services. Workers assess all kinship homes to ensure that caregivers can provide a safe environment, though the standards are considerably lower than for foster care licensure.

In California, Connecticut, and Indiana, workers reported that the agency is unlikely to open a case when a child is in voluntary kinship care.⁴ But some local agencies have greater resources for voluntary placements, which may lead workers to open a case and provide services. When opening a case is an option, workers assess the ongoing risk of voluntary placement to determine whether to keep a case open and for how long, and whether and how to supervise the kinship caregiver’s home.

Similar to the decision on whether to use kin voluntarily, workers are following unwritten rules to determine how to support and supervise them. So, practices vary considerably even within an office.

One of the primary goals of our nation’s child welfare system is to ensure that children who have been removed from their parents’ homes are reunified or placed in another permanent situation (i.e., adoption or legal guardianship) in a timely manner. Child welfare caseworkers and administrators in all sites visited acknowledged that the agency does not conduct traditional permanency planning when children are in voluntary placements. Even when the agency opens a case following a voluntary placement (as often happens in Alabama), caseworkers do not generally discuss termination of parental rights or adoption. Workers in Alabama noted they help kin obtain temporary legal custody, but consider this a permanent outcome as far as the agency is concerned.

What Support Is Provided to Private Kin Caregivers Who Seek Assistance?

Child welfare agencies vary considerably in how they support private kin caregivers who seek help from them. As mentioned earlier, private kin caregivers care for related children with no interaction with a child welfare agency unless and until they seek help. Depending on the specific circumstances of the case and the local policies and services available, caseworkers may refer private kin caregivers to community services, open a voluntary services case, help kin petition for custody, or help them through the adoption or guardianship proceedings.

In almost half the sites we visited, including all rural sites, workers or administrators noted that they will sometimes take custody of a child and license the kinship caregiver as a foster parent. But this practice is not without controversy. Workers noted that some private kinship caregivers seek child welfare assistance for the foster care stipends.⁵ Some workers try to discourage private kinship care providers from seeking assistance by telling them that if the child is made a ward of the state, there is no guarantee that the child will be placed with the kin. Other workers argue that regardless of the motivation, the

Much of the ongoing debate about kinship care reflects a larger debate about the mission and scope of the child welfare system.

state has no legal authority to take custody of the child, citing that there is no evidence of child abandonment if a relative has been caring for a child.

Summary and Discussion

When and how often child welfare workers rely on voluntary kinship care varies greatly across states. The use of voluntary kinship care varies among counties, among offices within a county, and among individual workers. In addition, agencies provide various types and levels of support to private kin caregivers who seek assistance from the child welfare agency. This variation in agency practices toward voluntary and private kinship care reflects differing local visions for the role and scope of the child welfare system.

In most states, child welfare agencies use voluntary kinship care on a fairly limited basis, when caseworkers believe that children face low risk of abuse or neglect based on specific case circumstances. In our study, California, Connecticut, and Indiana are representative of this view of voluntary kinship care. None of the states has clear policies, procedures, or guidance on when and how workers should rely on voluntary kinship care. Workers noted that they follow unwritten rules and commonsense social work to determine when voluntary kinship care is appropriate. Although caseworkers need flexibility to determine the best way to resolve a specific family situation, the lack of policy or practice guidance can lead to great variability in how different caseworkers resolve similar circumstances. Although caseworkers use their professional judgment to determine when children can safely remain with kin, workers' personal opinions of the degree to which families should be involved with the child welfare system influence their decisions.

States such as California, Connecticut, and Indiana may use voluntary kinship care, intentionally or not, to influence birth parents and kin. If, after a substantiated incident of abuse or neglect, a caseworker suggests that the birth parents place a child with kin, birth parents may feel that if they do not comply with this suggestion, their child will be placed in foster care. However, most of the workers we surveyed in these three states spoke cautiously about their use of voluntary kinship care, noting that they do not pressure birth parents to place their children with kin. They also noted that they

do not place children in voluntary kinship care, but help birth parents decide the best solution to the crisis.

In contrast, Alabama is representative of a handful of states that use voluntary kinship care whenever possible. Believing that keeping children out of the foster care system is often best, workers and administrators in Alabama openly discussed their use of voluntary kinship care as diversion from foster care. They see their approach to kinship care as a form of family preservation and question why a state agency should assume custody of a child who can be cared for safely by his extended family. Critics of Alabama's approach suggest that they are abdicating at least part of their responsibility for caring for these children. Although children in voluntary kinship care in Alabama receive ongoing supervision, they are not supported by foster care payments and may not have access to the same services as foster children. Also, child welfare staff do not conduct permanency planning for children in voluntary kinship care.

Much of the ongoing debate about child welfare agencies' use and support of kinship care reflects a larger debate about the mission and scope of the child welfare system. Child welfare agencies respond to children who have been abused or neglected and protect them from future harm. Yet it is unclear when and how child welfare authorities should intervene when an abused or neglected child has moved in with kin. When does a family's private crisis become a public concern, and when does the public concern end? What responsibility do child welfare agencies have to assess a kin's ability to protect a child? What responsibility do agencies have to monitor the well-being of children cared for by kin? What responsibility do agencies have to help birth parents whose children are cared for by kin address challenges they face so that they can parent again? Under what circumstances and for how long should child welfare agencies be responsible for providing financial support and services to children cared for by kin?

To answer these questions, child welfare agencies must determine whether to treat kinship care as an extension of the biological family, or as a type of temporary substitute care. If kinship care is merely an extension of the biological family, then child welfare

Additional research is needed that assesses the risk of different kinship care arrangements and helps guide child welfare agencies and staff in making these decisions.

agencies have limited responsibility for children in kinship care. Child welfare agencies have no reason to intrude into private family matters unless children are at significant risk of abuse or neglect. What may be difficult to gauge is the risk a child in kinship care faces. Without ongoing monitoring, child welfare agencies cannot determine whether kin can prevent birth parents from maltreating their children, not to mention whether kin are abusive or neglectful themselves. Abuse and neglect are possible in all families. If child welfare is to treat kinship care as an extension of the biological family, then agencies have no reason to monitor kinship care placements without evidence of abuse or neglect.

If child welfare agencies view kinship care as a substitute placement, that is, child welfare staff have determined the child is at risk of abuse or neglect and needs to be removed, at least temporarily, from the parents' care and custody, then it seems that the agency should be responsible for monitoring the child's well-being and planning for the child's permanency. Moreover, to the extent that financial assistance influences the well-being of children in out-of-home placement, child welfare agencies should provide the same financial assistance to children whether they are placed with kin or in non-kin foster care.

Most states treat kinship care both as an extension of the biological family and as a temporary substitute placement, depending on how and if child welfare becomes involved and the ongoing risk children face. The challenge that states face is determining when, after becoming involved in a family crisis, child welfare agencies need to stay involved or whether kin can provide adequate safety for a child without agency involvement. States must also determine when and how to become involved when kin that have been caring for a child without child welfare involvement seek assistance. Additional research is needed that assesses the risk of different kinship care arrangements and helps guide child welfare agencies and staff in making these decisions.

Notes

1. Alabama: Jefferson (Birmingham), Mobile, and Taladega Counties; California: Los Angeles, San

Diego, Santa Clara (San Jose), and Santa Cruz Counties; Connecticut: Bridgeport, Hartford, and Torrington Counties; and Indiana: Lake (Gary), La Porte, and Marion (Indianapolis) Counties.

2. Florida, Kentucky, Ohio, South Carolina, Utah, and Virginia (Jantz et al. 2002).
3. It is important to note that since the signing of a consent decree in the early 1990s Alabama has implemented comprehensive child welfare reforms emphasizing family-centered services and a reduction in out-of-home placements.
4. As mentioned earlier, in these states voluntary placements are most likely to occur when the risk to the child is not sufficient to warrant opening a case.
5. If the child were a foster child, a kinship caregiver would receive a greater monthly stipend than he would through the non-needy relative Temporary Assistance for Needy Families payment. Thus, policymakers worry that the system provides these private kin caregivers with an unintended incentive to seek assistance from the child welfare system as opposed to the welfare office.

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- Ehrle, Jennifer, Rob Geen, and Rebecca L. Clark. 2001. "Children Cared for by Relatives: Who Are They and How Are They Faring?" Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Policy Brief B-28.
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About the Authors



Karin Malm is a research associate in the Urban Institute's Population Studies Center. Ms. Malm specializes in child welfare issues including research on kinship care and adoption.

She is currently managing a study examining how child welfare agencies identify, locate, and involve fathers of foster care children.



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This series is dedicated to the memory of Steven D. Gold, who was codirector of *Assessing the New Federalism* until his death in August 1996.

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COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

May 20, 2003

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

AND: Nutrition Directors

FROM: Carol Cooper Driskill

SUBJECT: SERVICE STANDARD REMINDER & BEST PRACTICE: FIRE DRILLS

Congregate Nutrition Service Standard: Fire Safety (page 5): "Fire drills shall be conducted at least quarterly, in accordance with local fire marshal recommendations; documentation is required. During the fire drill, fire exit routes shall be designated and reviewed. Staff shall be knowledgeable about the location and operation of all fire extinguishers at the site."

During monitoring, I have recommended that AAAs consider contacting the local fire marshal about fire drill documentation and conducting and critiquing an annual fire drill at each site. In case of an actual fire, the fire department would have prior knowledge about site location, layout, participants, and potential obstacles. In addition, the fire department might be willing to provide a program for participants and training for staff and volunteers.

Regarding fire drill documentation, I usually recommend: number of participants, evacuation time or drill starting and ending times, problems encountered, and comments. A separate form is not required as long as all the information is included. For example, writing the applicable information on the daily activity log is acceptable. Attached are examples of reports used by other AAAs:

- Emergency Evacuation Drill Report (JABA)
- Appalachian Agency for Senior Citizens Fire Drill Report
- Senior Connections Fire Drill Form
- MEOC Fire Drill Form

Please contact me with any questions or comments. Thank you.



[illegible]

**APPALACHIAN AGENCY FOR SENIOR CITIZENS
FIRE DRILL REPORT**

DATE: _____

SITE: _____

SITE MANAGER: _____

ALTERNATE MANAGER: _____

TIME OF DRILL: _____

TIME DRILL COMPLETED: _____

TIME TAKEN TO EVACUATE: _____

NUMBER OF OCCUPANTS: _____

WEAKNESSES: _____

AREAS IMPROVEMENT NEEDED: _____

STRONG POINTS: _____



EMERGENCY EVACUATION AND FIRE DRILL FORM

Café: _____ **Date of Drill:** _____

Total Number of Participants Evacuated: _____

Number of participants in the following categories:

Visually Impaired: _____ **Hearing Impaired:** _____ **Confused:** _____

Ambulates with Cane or Walker: _____ **Uses Wheelchair:** _____

Start Time of Drill: _____ **Total minutes taken to Evacuate:** _____

Weather Conditions: _____

Comments and/or Problems:

Signature of Staff Conducting Drill: _____ **Date:** _____





Mountain Empire
Older Citizens, Inc.

EMERGENCY EVACUATION AND FIRE DRILL FORM

Site: _____

Date of Fire Drill: _____

Number of Handicapped/Disabled Participants who fall into the following categories:

Vision Impaired: _____ Hearing Impaired: _____ Confused: _____

Ambulates with Cane or Walker: _____ Uses Wheel Chair: _____

Total Number of Participants Evacuated: _____

Time to Evacuate (Minutes): _____

Problems: _____

Signature of Nutrition Site Manager: _____

Date: _____



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

AND: Nutrition Directors

FROM: Carol Cooper Driskill

DATE: May 20, 2003

SUBJECT: Best Practice: Cash Management & Accountability of Client Donations

Last year I requested Best Practices for accountability and cash management of donations, especially for home delivered meals clients. The attached response is from League of Older Americans Area Agency on Agency regarding home delivered meal donations. Thank you



Best Practices
Cash Management & Accountability of Client Donations
February 2002

Name of Area Agency on Aging: League of Older Americans Area Agency on Aging

Contact Name & Telephone Number: Michele M. Daley 540-345-0451

Summary of program practice or approach:

Each month our volunteers deliver a monthly "client letter" that includes a variation of nutrition information, upcoming closings, other agency services, and always includes a note about contributions with an envelope and donation slip for them to mail back.

Objectives: To give each client the opportunity to donate to the program on a monthly basis.

Challenges/obstacles: Sometimes they hand their donation to the volunteer instead of mailing it, which makes it less anonymous.

Steps taken to address challenges/obstacles: We do let the volunteers accept it, because we don't want to discourage the client from donating, but we do make sure they get a receipt and we keep a copy (we use the little carbon copy receipt books).

Future plans:

Comments and/or Recommendations: Because we serve breakfast and lunch, we have a place on the donation slip where they can indicate how much money they want to be allocated to each program.

Thanks for your input! Please fax survey to Carol Driskill, Program Coordinator at (804) 662-9354



COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

**TO: Executive Directors
Area Agencies on Aging**

AND: Nutrition Directors

FROM: Carol Cooper Driskill

DATE: May 20, 2003

**SUBJECT: BEST PRACTICE – COMPLETION OF UAI & NUTRITION SCREENING
AT NUTRITION SITES**

Several months ago a Tuesday Mailing was sent requesting Best Practices for completion of the UAI and Determine Your Nutritional Health Checklist at congregate meal sites.

Thank you to everyone who responded. Information from the following AAAs is attached:

- Mountain Empire Older Citizens
- New River Valley Agency on Aging
- Rappahannock-Rapidan Community Service Board and AAA
- Appalachian Agency for Senior Citizens
- Jefferson Area Board for Aging

As a reminder, assessment and reassessment requirements under the new Congregate Nutrition Service Standard are also attached.



Best Practices
Completion of UAI Part A & Nutrition Screening at Congregate Nutrition Sites
September 2002

Name of Area Agency on Aging: Mountain Empire Older Citizens (MEOC)

Contact Name & Telephone Number: Nancy Smith 276-23-4202

Objective: Completion of UAI Part A (pages 1 – 4) and Determine Your Nutrition Screening Checklist on all new congregate nutrition site participants and annual reassessment (or sooner if client condition changes) of all site participants.

Summary of program practice or approach to achieve objective (Please note if you also complete UAI page 5 or 12 page UAI on congregate participants):
UAI Part A pages 1 – 5 completed in order to have medical information on all congregate participants. Helpful in case of illness at the site and for health education planning. Nutrition Screening Checklist completed at the time UAI is done (stapled to UAI form). Nutrition Screening Checklist completed annually at each site by Site Manager as site activity with discussion of each question. Forms are returned to Central Office and placed in participant files. Congregate UAI's completed by Site Managers and Case Managers.

Challenges/obstacles:

- 1) UAI's: Insufficient staff to do annual reassessments on congregate and home delivered meal participants. As the client population grows, the challenge grows.
- 2) Nutrition Screening: Initially, the Nutrition Screening Checklist was done either with the UAI or at a different time. Sometimes the Checklist did not get completed.

Steps taken to address challenges/obstacles:

- 1) Provide UAI training to all Congregate Site Managers so they can do initial UAI's or reassessments as needed.
- 2) The Nutrition Screening Checklist has been made part of the paper UAI and part of the computer UAI.

Future plans: Continue with the development of a systematic process by which all clients are reassessed annually. Staff other than Case Managers may be used.

Comments and/or Recommendations:

Thanks for your input! Please fax survey to Carol Driskill, Program Coordinator at (804) 662-9354

Best Practices
Completion of UAI Part A & Nutrition Screening at Congregate Nutrition Sites
September 2002

Name of Area Agency on Aging: New River Valley Agency on Aging

Contact Name & Telephone Number: Tina King 540-980-7720

Objective: Completion of UAI Part A (pages 1 – 4) and Determine Your Nutrition Screening Checklist on all new congregate nutrition site participants and annual reassessment (or sooner if client condition changes) of all site participants.

Summary of program practice or approach to achieve objective (Please note if you also complete UAI page 5 or 12 page UAI on congregate participants):

I & A staff complete pages 1 – 5 of the UAI and the Nutrition Screening Checklist on all new congregate participants either in the participant's home or at the Agency. Some are completed at the senior centers where nutrition sites are located. For reassessments, these are scheduled at each nutrition site annually. Several staff go and complete the forms in one to two days per site.

Challenges/obstacles: Sometimes participants don't attend the nutrition site the day of reassessments.

Steps taken to address challenges/obstacles: An appointment is made with the participant to meet them at their home to complete the reassessment or another date is set to meet at the site.

Future plans:

Comments and/or Recommendations:

Thanks for your input! Please fax survey to Carol Driskill, Program Coordinator at (804) 662-9354

Best Practices
Completion of UAI Part A & Nutrition Screening at Congregate Nutrition Sites
September 2002

Name of Area Agency on Aging: Rappahannock-Rapidan CSB & AAA

Contact Name & Telephone Number: Irma Peters

Objective: Completion of UAI Part A (pages 1 – 4) and Determine Your Nutrition Screening Checklist on all new congregate nutrition site participants and annual reassessment (or sooner if client condition changes) of all site participants.

Summary of program practice or approach to achieve objective (Please note if you also complete UAI page 5 or 12 page UAI on congregate participants):
Currently we do pages 1 – 3 of the UAI. These are done by our Case Managers as well as the initial nutrition screen for congregate and home delivered meal clients. Follow up nutrition screens are done by Site Coordinators on congregate participants. Home delivered meal clients are done by Case Manager when UAI is updated.

Challenges/obstacles: Initial home visit seeks a lot of information. Follow up yearly for each UAI is time consuming.

Steps taken to address challenges/obstacles:

Future plans: No change

Comments and/or Recommendations: I like the short form for congregate!

Thanks for your input! Please fax survey to Carol Driskill, Program Coordinator at (804) 662-9354

Best Practices
Completion of UAI Part A & Nutrition Screening at Congregate Nutrition Sites
September 2002

Name of Area Agency on Aging: Appalachian Agency for Senior Citizens

Contact Name & Telephone Number: Shirley H. Lunsford 276-964-4915 and Dana Collins, Director of Care Coordination

Objective: Completion of UAI Part A (pages 1 – 4) and Determine Your Nutrition Screening Checklist on all new congregate nutrition site participants and annual reassessment (or sooner if client condition changes) of all site participants.

Summary of program practice or approach to achieve objective (Please note if you also complete UAI page 5 or 12 page UAI on congregate participants):
Completion of UAI pages 1 – 4, a page required by AASC, a consent form, and Determine Your Nutrition Screening Checklist are done by a case manager or site manager, then the package goes before eligibility committee for determination. Case manager does a phone interview or in-home assessment and site managers complete UAI and other forms at the nutrition site.

Congregate site annual reassessments completed by site managers and participants at sites, then returned to central office for determination. Site managers refer clients for reassessment, if there is a change in condition of clients before annual review.

Challenges/obstacles:

- 1) Getting consent form and other forms signed, if UAI completed via telephone.
- 2) Incomplete UAI's sent in from sites.

Steps taken to address challenges/obstacles:

- 1) Mail forms to client with return addressed envelope and areas of concern highlighted.
- 2) Call client or site manager to capture missing information.

Future plans: More staff training on importance of thorough documentation.

Comments and/or Recommendations: We recommend Quick Form use for special events such as our spring festival and county fairs. Many participants receive a meal one time a year and will not allow us to complete a full UAI for the one time congregate meal. Continuation of the 4 page UAI recommended for all other congregate clients.

Thanks for your input! Please fax survey to Carol Driskill, Program Coordinator at (804) 662-9354

Best Practices
Completion of UAI Part A & Nutrition Screening at Congregate Nutrition Sites
September 2002

Name of Area Agency on Aging: Jefferson Area Board for Aging (JABA)

Contact Name & Telephone Number: Deborrah Foreman 434-817-5227

Objective: Completion of UAI Part A (pages 1 – 4) and Determine Your Nutrition Screening Checklist on all new congregate nutrition site participants and annual reassessment (or sooner if client condition changes) of all site participants.

Summary of program practice or approach to achieve objective (Please note if you also complete UAI page 5 or 12 page UAI on congregate participants):

See attachment – Example of JABA's Louisa County Team Approach to UAI and Nutrition Screening Initiative assessments and reassessments. When referrals are made to nursing staff or Aging Service Coordinators, addition pages are completed.

Challenges/obstacles: Need funds to enhance technology, etc. to have more AIM seats, scanners, etc. Paperwork load is too much for Senior Center staff alone. Some clients are more comfortable talking to the same gender.

Steps taken to address challenges/obstacles: 1) Team approach, 2) Advocating for improved technology, 3) Dietetic Interns assist with Nutrition Screening and develop nutritional profiles of centers and recommendations for nutrition education, intervention, menus, etc.

Future plans: AIM seats in each jurisdiction with technology enhancements enabling scanning of required paperwork, client codes, etc. Team approach in each jurisdiction (improved).

Comments and/or Recommendations:

Attachments

Thanks for your input! Please fax survey to Carol Driskill, Program Coordinator at (804) 662-9354

Implementation Plan for Completing UAI Part A and B, Consent and Release Forms and Nutrition Surveys on Congregate Clients

Senior Center Intake and Assessment Team*

Staff responsible for UAI Completion and consent and release forms:

1. Lead Staff: Center Supervisor
2. Center Supervisor: Part A only, pages 1 – 4
3. Aging Services Coordinator: Assist the Center Supervisor and nurses when requested at monthly visits to the centers. (Note: some centers do not have nurses on staff and will require more support)
4. Nursing staff: As clients/patients are seen, nursing staff will determine how much of the UAI, Part B will be completed. Nurses will assist Center Supervisor as necessary.

Staff responsible for Nutrition Survey Completion

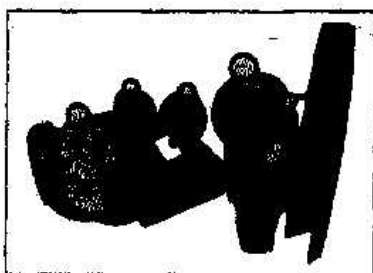
1. Lead staff: Center Supervisor
2. Center Supervisor: The center survey can administer this survey.
3. Nursing Staff: Nursing staff can also administer this survey. At monthly meetings, staff can determine who will complete the survey. This can vary according to staff needs and client needs.

*All staff responsible for UAI completion must participate in UAI training annually at the central office by designated trainers. Twice a year, JABA will offer review training focusing on interviewing skills.

** The Assessment and Intake Team must meet monthly to discuss clients, UAIs and task assignments.

UAIs/Consent Release Forms Nutrition Surveys Completion Schedule:

1. If a new client joins prior to the 15th of the month, the UAI Part A pages 1-3, consent and release form and the nutrition survey needs to be turned in that month. Any new client that joins after the 15th of the month the UAI is turned in the next month.
2. The new client nutrition survey must be done again 6 months later from intake date.
3. Nursing staff must complete UAI Part B.
4. Nursing staff and Aging Service Coordinators are expected to help with the UAIs that Center Supervisors have not been successful at completing.
5. Special programs such as exercise classes will require clients to complete the medical screening and release forms. Participation will not be allowed until these forms are completed.
6. Every October or once a year, all UAIs are reviewed, updated and turned into Central Office for input. Highlight and date changes with red ink. Consent and release forms must also be completed and turned in every October.
7. UAIs must be updated throughout the year as necessary. (ex: client's health changes) Highlight and date the changes and turn into the central office for input with red ink.
8. Clearly identify what senior center the UAI, consent and release forms, and nutrition surveys are from. Please sign all forms
9. All enrolled Senior Center participants are placed on the agency newsletter mailing list.
10. Center Supervisors must file all intake forms in one of two sections 1)active or 2) inactive. These files must be kept on site.



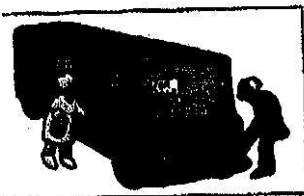
TRAINING PACKET

COMPLETION OF SENIOR CENTER UAI



PROCESS AND GUIDE

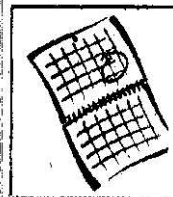
Prepared by JABA/Louisa Team
September 13, 2002



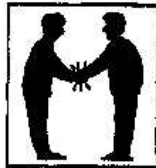
New Members



- Activity Coord. (AC) has the initial responsibility to approach new members, to greet them, explain the program, and to complete the necessary paperwork.
- Once the senior activities begin, AC may be unable to assist new members. It then becomes Experience Works Employee (EWE) responsibility to approach new members, to greet them, explain the program, and to complete the necessary paperwork.
- In the event AC and EWE are absolutely unable to complete the member forms then the responsibility goes as follows. This chain must be strictly adhered to:
 1. Site Supervisor must be notified. Site Sup. will determine why staff is unable to complete the membership paperwork. If a valid reason exists, Site Sup. will then complete the paperwork or identify who is available.
 2. If Site Sup. is not on the property, then ADC Director should be notified. She then will assign a staff member to complete the paperwork.
 3. If Site Sup. and ADC Director are not available, then the ASCs need to be notified.
- AC and EWE should communicate daily on planned activities to make sure someone is available to assist new members.
- AC and EWE will receive training as outline in this packet. The training offers a guide to completing the UAI and other forms as well as the procedure to follow in assisting new members.

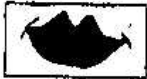


- AC and EWE will be given access to all of the necessary forms, supplies, and assistance that they need from the staff.
- Site Sup. is available to answer any questions as they arise after this training has been completed.



WELCOME

- AC greets new members as they enter the senior center before they are seated if possible unless they are unable to stand. If AC is unavailable (example: involved in an activity then EWE is to greet the new member(s).



(Possible Script)

"Welcome. I'm _____. Have you been to the Senior Center before? Are you familiar with our programs and activities?"

"Well, we usually start with devotionals in the morning, followed by speakers, exercise programs, and arts and crafts. We then have lunch about 12 noon. In the afternoon we play bingo, walk, crafts, etc. Tues and Thurs every week we have nurses here to check blood sugars, take blood pressures, talk with you, and answer any medical questions you have."

"Are you interested in becoming a member or are you planing on staying for lunch today?"



- If they say **NO** (I'm not interested in becoming a member), then inform them that if they decide to stay for lunch it will cost \$4.25. Direct them how to pay.



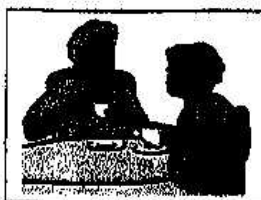
"OK. Make yourself comfortable. There are no assigned seats. The restrooms are over there and down the hall on your right side. If you decide to stay for lunch, it will cost \$4.25. You can pay _____ at the table at the front. I hope you enjoy your time with us today."



- If they say **YES** (I'm interested in becoming a member), then direct them to a seat where you can speak with them privately.



- Go and pick up a blank folder with all of the forms needed.
- Join the member at the private table you have selected.
- Explain the necessity for the paperwork. Ask them if they would like to complete it themselves with assistance as needed or if they would prefer you ask the questions. (**Remember some people do not read and write well. If a person is unable to read they may wish to have someone witness their signature.)





"To become a member of the senior center, we are required to complete certain paperwork because we are funded in part by the State and Federal government. The rest of the money comes from donations from the senior center members. Once you become a member you are not required to pay for your lunch. However we ask each member to make a donation to support the program. Without your donations the center will be unable to serve everyone. The donation baskets are on each table."

"Do you feel comfortable completing the paperwork with me today?"



- If person is interested in becoming a member but would prefer to do paperwork another day, let them know that you need their full name and social security number. Tell them they can complete the paperwork on their second visit but after that they will be required to pay \$4.25 per visit until they are available to answer the questions.



- Please let each new member that all the information they share with us is confidential.
- Begin with the UAI. You may use the sheet we have provided for you as a guide on asking the questions. The UAI QUESTION SHEET is numbered and shows you where on the UAI to record the answers. A UAI QUESTION SHEET cannot be turned in to the Site Sup. in place of a UAI.

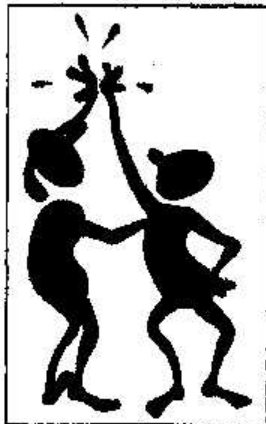
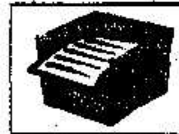
- Attach the UAI QUESTION SHEET to the back of the UAI. Please highlight any information you feel the site supervisor needs to pay special attention to.
- Complete the other forms in the following order: Consent, Nutrition Survey, and CDBG Form.
- Once all of the paperwork is complete, direct the member to a seat.



"OK. Make yourself comfortable. There are no assigned seats. The restrooms are over there and down the hall on your right side. Thank you for coming today. I hope you enjoy your time with us."



- Place all of the completed forms in a manila folder.
- Write the members name (last name, first name) on the folder
- Turn the folder into David. He will identify a place in his office where new folders are to be placed.



You're done!

Congregate Nutrition Services

Assessment

- A service-specific assessment using the Uniform Assessment Instrument shall be performed on each potential client or other eligible individual (not a volunteer) that determines whether the individual is eligible for the service, the amount of the individual's service-specific need, and the individual's level of priority for service delivery.
- Uniform Assessment Instrument pages 1 – 3 minimum, and “Determine Your Nutritional Health” Nutrition Screening are required. The AAA may complete additional pages of the UAI. The AAA may develop and use a form (in place of the UAI) to be completed by the senior, when appropriate, as long as all UAI information is collected.
- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Cost sharing does not apply to this service.
- For an individual who provides volunteer services during the meal hours (not a site participant) and receives a congregate meal: the full legal name and service units (collected at least on a monthly basis) must be entered into AIM; the Social Security number is recommended but not required.

Nutrition Screening

“Determine Your Nutritional Health” Nutrition Screening checklist developed and distributed by the Nutrition Screening Initiative must be completed during assessment. The AAA or service provider will develop a written plan specifying how the agency will use the screening results.

Reassessment

- A review of the participant's need for services, the amount of services provided and the appropriateness of the care plan (if completed) shall be performed when the participant's condition or situation changes, but at least annually.
- Uniform Assessment Instrument, pages 1 – 3 minimum, and “Determine Your Nutritional Health” Nutrition Screening shall be updated at the same time.
- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Cost sharing does not apply to this service.